

CASE 3.—Mr. T. M., a 22-year-old college student, complained of an area on the outer side of the right thigh (Figure 1) that was numb and tingled, and at times was slightly painful. An area was discovered about the size of one's hand where light touch and painful stimuli were not perceived. Symptoms gradually disappeared in the course of four or five months, and there has been no recurrence in five years.

None of these cases received treatment.

SUMMARY

1. Meralgia paresthetica is defined and its etiology, pathology, and treatment discussed.
2. The likelihood that the disease is not uncommon is suggested.
3. Histories of three cases are presented.

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PHLEBITIS: ITS TREATMENT

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IN view of the frequent incidence of phlebitis, and the fact that six per cent of postoperative deaths are due to its sequelae, sepsis and pulmonary embolism, it is fitting that more attention be directed to its treatment.

Phlebitis, when not chemical, is caused by three factors: infection, plus either stasis or trauma, or both. The probabilities are strong that so-called traumatic thrombosis, over which there is now so much medico-legal discussion before the Industrial Accident Commission, occurs with infection as a contributing factor. The absence of a positive blood culture proves nothing. What is conclusive is the work of French surgeons, who cut down on the thrombus in "traumatic" thrombosis, and who repeatedly obtained heavy cultures of streptococcus and staphylococcus from the thrombus.¹

Preventive Treatment.—Phlebitis, after operation, may be prevented by avoiding stasis in the veins. This requires that in postoperative care the patient must be taught to move his legs at least five times a day and take frequent deep breaths, beginning as soon as he comes out from under the anesthetic. This provision should be continued until he is out of bed. The leg movements propel the venous blood, and the deep-breathing movements of the thorax aspirate it.

Severe phlebitis, after injection of varicose veins, is due to infection. This infection may be prevented by using, in very large veins which are most susceptible to phlebitis, only the strongly bactericidal solution of quinin urethane.² This quinin is adsorbed into the endothelial cells.

ACUTE PHLEBITIS

Curative Treatment of Acute Phlebitis demands compression of the superficial veins with an elastic, linen-mesh bandage. If the phlebitis extends above the knee, it will be necessary to use, from the knee up, an adhesive elastic bandage, such as the

elastoplast bandage, for the ordinary linen-mesh bandage will not stay on above the knee. The compression of these superficial veins is the outstanding factor in treatment. The compression bandage should be carried continuously up above the level of the phlebitis, for there is a strong opinion, which originated with the late Sicard of Paris, that an embolus is thus less likely to be liberated.

The common treatment by ice packs in acute phlebitis is dangerous: since the tissues suffer both from infection and venous stasis, and the lymphatic obstruction always associated with phlebitis, they have low resistance to the ice. One such patient who came to the author had a gangrene, due to the ice, extending from the ankle to the upper thigh and deep through the skin, and subcutaneous fat far down into the sloughing muscles. She was moribund. (Treatment of this ice-burn with tannic acid saved both the leg and the patient's life.)

Another still more common error is prolonged immobilization of the phlebitis patient in bed. This customary treatment is based on the ordinarily sound principle of treating infection with local rest to the part. It, however, overlooks blood stasis as a fundamental factor in causing phlebitis: the bacteria thrive on stagnant, degenerating blood elements. The modern procedure gets the patient out of bed early, and the results have justified the change. It takes some judgment to know how soon to get the patient out of bed. If this procedure is followed with good judgment, the danger of embolism is not as great as the danger of embolism from allowing venous stasis to continue by long bed rest. The common practice of keeping phlebitis patients in bed for seven weeks is strongly to be condemned.

CHRONIC PHLEBITIS

Treatment of chronic phlebitis requires bandage treatment as above. A few patients are not cured by the bandaging, and after a period of time, such as two or three months, they should be treated by high voltage x-ray, as described by Halban.² Roentgen treatment is of great value in old, chronic phlebitis, especially chronic phlebitis with edema. Roentgen treatment should never be used until the phlebitis has been chronic for a long time.

It is sometimes impossible to draw a sharp line between chronic phlebitis and Buerger's disease. In fact, phlebitis migrans probably is Buerger's disease. Too much emphasis cannot be laid on the prohibition of smoking in these cases.

Watch for the case of chronic phlebitis which shows no enlargement of the leg on the affected side. Many of these patients are no longer suffering from chronic phlebitis. Their misery is due to pes planus.

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¹ Delater: *Les Maladies des Veines*, Masson et Cie, Paris. This is the greatest and most comprehensive study of diseases of veins ever written.

² Halban, Joseph: *Strahlenbehandlung bei Thrombophlebitis*, Wiener Klinische Wchnschr.; 43:1368 (Nov.), 1930.

An Arab proverb runs as follows:

"The world is supported by four columns:

The justice of the great

The prayer of the righteous

The bravery of the valiant, and

The science of the physician."